New Hampshire

Inhaled Insulin Medications

First Health Services Corporation
A Coventry Health Care Company

NH Medicaid Prior Authorization
Request Form

Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ___ ___ /___ ___ /___ ___ _

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____ NH Medicaid Number:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name:_____ Strength:_____

Dosing Directions:_____ Length of Therapy:_____

Section II: Clinical History:

1. Is patient ≥ 18 years of age? ☐ Yes ☐ No
2. Does patient have a diagnosis of Type 1 or Type 2 diabetes? ☐ Yes ☐ No
3. Is the patient a non-smoker? ☐ Yes ☐ No
4. If the patient was a smoker, has the patient stopped smoking for more than six months prior to starting inhaled insulin therapy? ☐ Yes ☐ No
5. Has a baseline FEV_1 been established for this patient prior to starting inhaled insulin therapy? ☐ Yes ☐ No
6. Is patient's baseline FEV_1 greater than 80%? Please provide measurement. _____% ☐ Yes ☐ No
7. Does patient have a diagnosis of COPD, asthma, emphysema, or poorly controlled lung disease? ☐ Yes ☐ No
8. What is patient's HgA1C prior to initiation of inhaled insulin therapy? _____%
9. For Type 1 and Type 2 diabetics: Is patient unable to inject insulin or has a history of treatment failure with fast acting SC insulin? ☐ Yes ☐ No
10. For Type 2 diabetics: Has patient failed to attain adequate glycemic control on maximum tolerated doses of combination therapy of sulfonylureas, metformin, and TZDs? ☐ Yes ☐ No

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

_____
_____
_____
_____
_____
_____

Section III: Prescriber Information:

Print Name: _____ DEA Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

_____
Signature of Prescribing Provider

Revised 11/28/06